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MEDICAL RATIONING

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As your newly elected president I have given considerable thought to the responsibilities which this position entails. I am convinced that the most pressing current problem confronting the medical profession of Rhode Island is the impending shortage of practitioners to care for the civil population.

I believe that the necessity for rationing medical services is probably infinitely more important than all other types of rationing because our medical resources are now definitely and steadily diminishing, with no possibility for replenishment.

It is now clear that there will not be a shortage of doctors in the armed forces and it is generally conceded that before this war ends every physically and professionally qualified doctor under forty-five years of age will be in the armed services. Various estimates of the number required in the near future, that is, by the end of the year, have appeared but it is certain that at least two hundred practicing physicians from Rhode Island will be in service by that date. Definite quotas have been set and machinery for medical recruitment is at work.

Man-Power Chairman, Paul V. McNutt, in Atlantic City, June 8th clearly stated the following "An army of 9 million will take 12 per cent of our male population. Present Medical Corps ratios indicate the armed forces will require 33 per cent of all our physicians (including retired men)—two-thirds of all those under the age of 45."

"For the military services younger men must go. They must realize their duty now. The armed forces need thousands of young doctors immediately—to be exact, 5,000 by July 1, 20,000 during the next 7 months."

This is a young man's war beyond any question. Young doctors definitely make the best medical officers. For this reason the most important factor in availability for armed service is age. The critical age level is set at 45, granting always that the doctor is a graduate of a class A school and physically fit.

Hence, when we begin to ration our available medical resources we start with doctors who have passed their 46th birthday, those under 45 who are physically unfit, women physicians, graduates of the substandard schools and alien doctors. There may be a rare instance of a doctor under 45 being absolutely essential to his community. Certain other doctors are essential such as full-time industrial surgeons in war industries and possibly an odd doctor essential to the administration and operation of a hospital.

Many men may not be available at this time who later can be listed as available. Dependency apparently does not enter into the question of availability. This question of availability is part of the function of the Procurement and Assignment Service. This service does not determine a man's draft classification. This is done only by his local draft board. The same rule applies whether he be plumber, clerk, or physician. This Procurement and Assignment Service may be called upon for advice by selective service boards and particularly as to essentiality but classification always remains with the local selective service board.

The total number of licensed doctors of medicine in Rhode Island is about 975. However, many of these do not reside in Rhode Island and this figure as supplied by the Division of Examiners of the Depart-

ment of Health does not in any way give a picture of the number in practice, as we do not have a yearly renewal of license and the department has no accurate knowledge of those who relinquish practice by retirement, disability or death. The figure of 961 as supplied by the American Medical Association directory of 1940 is probably a much better estimate but includes certain migratory names such as hospital interns and residents.

My own best guess is that there would normally be about 800 doctors of medicine practicing in Rhode Island. Therefore with a minimum of 200 in service it can be definitely stated that a deficit of 25% will exist by January 1, 1943. There will be no increase to speak of from new practitioners leaving internships except an occasional woman or physically unfit man.

How then are we going to ration our available medical service so that no sick person shall go unattended? Rhode Island has long been accustomed to medical services, both paid and free, generous in quantity and high in quality.

The hospitals offer no solution of our problem. Bed occupancy is practically total at this moment. Admissions have increased 14.95 per cent in 1941 compared to 1940 (according to the census of the Hospital Council on Medical Education and Hospitals of the American Medical Association).

Where will hospitals get the medical, nursing and technical staff to care for more patients when it is so difficult to meet current needs. Already our hospitals are drastically rationed as to visiting and interne staffs. Our local solution can in no way be solved by sending more of the sick to hospitals.

I find no easy solution of this problem and believe it will try the energies and capacities of the older doctors to their utmost. Retired and semi-retired doctors, if able, will need to re-enter practice. Specialists, and those who limit their practice, must widen their services. Many general practitioners will need to limit their office hours to permit more house calls and older members of the profession will need to increase their hours of practice. Although I present these many difficulties we know that our profession will not fail in this emergency and that our usual high quality of service will be maintained.

THE PRACTITIONER AND THE ALLERGY PROBLEM

With Special Reference to Respiratory Allergy

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The incidence of allergy has never been accurately determined, but if one takes an average of the various figures obtained from the most reliable sources I think we may safely say that "significant" allergy, that is, clinical allergy causing sufficient disability to require medical care at one time or another, occurs in from 7 to 10 per cent of the general population.

Allergy was not dignified with a place in the International Classification of Causes of Disease of 1917. During World War I—I cite Warren Vaughan's figures culled from Vol. 15 of the statistical report of the Army Medical Department—only 2 per 1000 were rated asthmatic, but 15 years later the figure had risen to 12 per 1000 among veterans receiving compensation, and 17 years after the war the Government was paying nearly \$5,000,000 annual compensation on account of asthma alone, and this in spite of the fact that the Draft Boards had previously rejected asthma with bronchitis and emphysema at the rate of 2.45 per 1000.

In the present war, in spite of the fact that "significant" allergies are supposed to be grounds for rejection, the word that comes to us from medical friends in service indicates that the mistakes of the last war are being repeated. While those in the Army Medical Corps trained in allergy find use for their experience in various hospitals, it is true that allergy is a problem not yet adequately handled, for men are inducted that should be refused, others are discharged that might easily be retained and uniformity of management on the part of the Selective Service Boards and in the various hospitals of the Army does not yet obtain. What is true in the Army is also true in industry, where significant allergy is a frequent and compensable disease, and rulings of Compensation Boards today lack uniformity and in many instances are unfair both to employer and employee.

If this is true, and facts bear me out that allergy

Read before The Rhode Island Medical Society June 3, 1942. From the Department of Allergy, Roosevelt Hospital, New York City.

is a real problem in the Armed Forces and in industry, how much more is it true on the home front, where all of you practitioners of medicine are seeing these cases in presumably the earliest stages at a time when diagnosis and proper management means so much in preventing minor evidences from becoming major afflictions.

Allergy is a term that is more easily described than defined and frankly one on which there is not entire unanimity of opinion. The word does not describe a single histological, immunological or clinical entity. By it we mean to convey the basic concept of tissue sensitization, for all reactions are cellular, that is, are mediated by an antibody mechanism which binding antigen to cell results in evidences of disease that are not normal or usual for the antigen or the cell. For example, the egg-sensitive child or the pollen-sensitive man give reactions to these antigens that have nothing to do with either egg or pollen and cannot be duplicated on a normal subject. It is the sensitization factor that determines the abnormal character of the reaction. So is it with the cases of bacterial allergy in which the clinical expression may be hyperplastic sinusitis, asthma, urticaria, angioedema, or dermatitis, for all of these are frequently due to infection, or rather to a sensitization to the bacteria or their products. Certainly such clinical conditions are not the usual result of chronic or acute invasion by any of the ordinary pathogens, yet we see patients in whom the injections of minimal doses of an autogenous pneumococcus vaccine, for example, will induce an attack of asthma—the symptomatic reaction—and I recall a patient with chronic urticaria for several years' duration relieved almost overnight by the incision and drainage of a chronic perineal abscess from which *Staphylococcus* and *B. coli communis* were recovered.

In a certain type of allergy, as for instance in a case of hay fever, the introduction into the skin of the proper antigen, or allergen if you will, produces promptly an active urticarial wheal or local reaction, and a too large dose induces, within a relatively few minutes, hay fever with general urticaria and perhaps asthma—the constitutional or symptomatic reaction. In such cases the antibody mediating the reaction is found in the patients' blood serum and sensitization may be transferred to a

nonallergic subject by the injection of serum. If a small amount of such serum is injected intradermally, that site becomes sensitized. If a transfusion is done with such blood, a general but temporary sensitization results. These cases positively reacting to the skin test form only a part, but a fairly important part, of the sum total of allergies, and constitute a sub-division of allergy called *atopy*. They are characterized by the promptness of the clinical, as well as the local, reaction of hyperemia and edema, and it is striking that the reactions are fundamentally identical whether the allergen be inhaled as pollen or animal dander or various dusts, or whether it be ingested as food or drug. In other words, the type of reaction is determined by the sensitization factor, not by the different antigens.

But there are many other allergies not susceptible to diagnosis by skin test and they constitute the most interesting as well as the most puzzling of types. Here the antigens may be foods, drugs, bacterial products or, rarely, airborne substances. As an example, let me cite a not uncommon case from our clinic. The patient, male, 35 years old, had asthma and hay fever, but in addition he had symptoms one might properly call mucus colitis. By the method of trial and error it was found that the avoidance of milk cleared up his intestinal symptoms entirely and his asthma partially. Feeding milk induced the symptoms, for 6 hours after its ingestion there followed abdominal discomfort, nausea, some asthma and then a number of loose mucus stools. His skin test with milk was negative. And why? Because he really was not sensitive to milk as such but to some split product of milk elaborated within the body after the lapse of 6 hours, when the symptoms began. This is a typical example of what I have chosen to call the "delayed" allergy. It is an allergy, but the patient is not skin-sensitive to the food that produces symptoms. The mechanism of this type of allergy is not entirely clear. Though we have some ideas on the subject I will not discuss them now; the point I wish to emphasize is that skin testing does not afford the answer to all allergies but only to a certain type of allergy called *atopy*. Other allergies that are not *atopies* are the infective or bacterial allergies. In them skin tests prove nothing. Their clinical evidences may be the same but their diag-

nosis is not, and the allergist of today does not consider himself a technician in skin testing but an interinst or practitioner trained in all the methods of diagnosis and treatment in a field in which he happens to have a special interest.

The methods however are not intricate or involved and may readily be applied by the general practitioner to good effect, particularly if he divests himself of the idea that skin testing is all there is to allergy. Frankly I would rather give up skin tests than I would do away with a careful history, a complete physical examination and the usual laboratory information.

Of all the diseases of allergy we are called upon to deal with, none is more common and none fraught with greater potentialities of ultimately serious and prolonged disability than those involving the respiratory tract, and so I shall deal with them as the main topic of my presentation.

Beginning as they so frequently do with manifestations of sensitization in infancy and early childhood, I want to draw for you a picture of the life cycle, if we may term it such, of respiratory allergy. This was a patient 60 years of age. His father had asthma, one sister has asthma and another has seasonal hay fever. In infancy our patient was acutely sensitive to egg. At 7 he developed coryza and asthma from all animal contacts and had frequent upper and lower respiratory infections. At 20 marked nasal obstruction was caused by hypertrophied turbinates and he began to have asthma with acute respiratory infections. At 40 he was still having asthma from animal contacts and showed evidences of chronic sinusitis requiring frequent antral irrigations and occasional removal of polypi. At 50 the asthma was mild but continuous and steadily increasing. At 57 he was completely incapacitated and at 60 he was hospitalized with status asthmaticus, and he died 4 years later from asthma, pulmonary fibrosis, emphysema and cor pulmonali. This is a brief sketch of a typical, not an isolated, example of a combined atopic and infective allergy that received symptomatic treatment only throughout life.

Let us now proceed to consider certain aspects in greater detail. Given an allergic family background, the respiratory allergies may start in infancy, in childhood or in early adult life. Such

sensitizations frequently involve the upper respiratory tract first, perhaps as a seasonal pollen reaction or as perennial allergy to airborne and environmental dusts, as animal danders, cosmetics, pyrethrum powder and even house dust itself. Usually the sensitizations are multiple, that is, from several up to many different allergens, and while one, such as ragweed pollen or the family dog, may dominate the clinical picture as a cause, the rest may be minor factors contributing to persistent but mild symptoms.

These patients as a rule are subject to frequent winter colds, perhaps merely head colds at first, but always with a tendency to bronchial infections which eventually develop into typical asthma attacks, often termed asthmatic bronchitis, stressing the bronchitis rather than the asthma, which runs its short course with eventual recovery. Too often the family physician fails to grasp the significance of these early mild, short and recurring infections in the allergic or the hereditary predisposed allergic child. The fact is that these early cases treated on a purely symptomatic basis are laying the foundations for further difficulty at an age when illness interferes more importantly with education, with physical development and later with a career. The recurring infections of childhood, involving the upper respiratory tract, are undoubted factors in the development of chronic sinus infections which may be significant factors in illnesses of the second and third decades but may not be active until even the fourth or fifth decade of life has been reached.

The cases of the age group I have been discussing belong generally in the atopic—the skin-sensitive group—but let us go back for a moment to the allergically predisposed infants, in whom infection is by all odds a more important cause of respiratory disease than inhalant or food allergies. Babies with recurring head colds and bronchitis in allergic families should be regarded as potential asthmatics, particularly if they have had even the mildest evidence of infantile eczema or food sensitiveness. There is no doubt but that infection in the allergically disposed infant and child is of the utmost importance in two ways. With recurring infection a bacterial allergy may be set up or acute infections in some way not yet understood stimulate the development of sensitization of the atopic type. The

object of stressing this point is to combat the common idea that infants and children tend to outgrow the early appearing asthma or vasomotor rhinitis. Occasionally they do, or more likely only appear to do so, but my experience and statistics would indicate that not more than 5 per cent are so fortunate. The time to attack the problem, for it is a problem, is before rather than after the asthmatic attacks begin. Children of allergic parents, or those with an infantile food sensitization or eczema regardless of familial history, who are subject to recurring upper or lower respiratory infections, such children I say should be given prompt consideration as allergy suspects, for there are corrective measures. Once an allergic always an allergic, or once an asthmatic always an asthmatic, are words in which there is much truth and much sorrow, but encouragement lies in the fact that the natural course may be interrupted.

What then are the general principles of management that may be used in the potentially allergic individual, the offspring of allergic forebears, or in those who show evidences of early allergy?

1. Those with a tendency to frequent respiratory infections should be studied to determine whether or not they have mild atopies to inhalants or perhaps foods, which predispose to the infections. If found in the very young the cause may be removed, or if this is not possible they may be treated by injection of the proper allergen.

2. In the predisposed and young allergics, extra care should be taken for the prevention by immunization of such infectious diseases as pertussis, measles and of course smallpox and typhoid, and by the use of toxoids for protection against diphtheria and tetanus, where otherwise recourse must at times be had to horse serum, which is always a potential danger in these cases. These preventive measures against the various infectious diseases if practiced routinely by the practitioner are of the greatest advantage in the management of the allergic or predisposed child, because acute infections of all types of and by themselves appear to activate an otherwise latent allergy.

3. If foci or infection are found, they should receive attention. In the very young and up to the early twenties most primary foci lie in the lymphoid tissue of the tonsils, lingual tonsils and adenoids.

It is my opinion, although I am aware that many do not agree, that the careful and complete surgical removal of infected tonsils and adenoids is one of the most beneficial measures in the allergic child with recurring respiratory infections, especially when done early and if possible before asthma has set in. My contention is that children predisposed to allergy must be considered as a special group and that their management is different from those not so hereditarily disposed.

By and large in our clinic we see very few cases of asthma due to *foods*; many in which it may be suspected at least by the patient but few in which it can be demonstrated by trial under clinical observation. The *inhalant* group of substances—dusts, pollens and danders—are common causes of asthma beginning between 7 and 30 years of age. *Infections* are common etiological factors acting alone and as primary factors in the age group from birth to 7 years of age, acting as secondary and concomitant factors with inhalant atopies in the asthma cases beginning in the 7 to 30 year old group and again as the important and often the sole factor in patients in whom asthma begins after 40 years of age. Many of these older age group patients may have had nasal allergy, a simple pollen hay fever, for years, but when they develop asthma after 40 years it is in our experience usually traceable to infection.

The older patient group with onset of asthma after 40 years contributes largely to the pitiful picture only too well known to all. The real onset of trouble may date back many years, perhaps only with a simple catarrh, oftentimes with recurring nasal polypi, then a bronchitic cough and finally the dyspnea of asthma sets in. Usually symptomatic medication only is given when such patients first consult the physician, then they learn that this merely allays but does not stop the progress of their affliction. They resort to patent medicines, advertised panaceas and irregular practitioners of the various healing cults, so-called. In our analyses of a large number of these cases, that is the group with onset of asthma after 40 years of age, 85 per cent have been found to have primary foci of infection in the upper respiratory tract and 15 per cent to have a primary chronic bronchial infection to which they have developed a bacterial allergy. You

practitioners should eagerly grasp the opportunity to help these patients, for it is to you they come first. These primary foci could and should be found, for they exist years before the chest symptoms develop. The specialist usually sees them as a last resort and after years of illness when the opportunity for best results has passed. In such cases the primary foci exist in teeth, tonsils and sinuses, and the proven existence of a focus should call for prompt measures. Infected teeth and tonsils are readily removed. The difficult question to decide is the type of attack to be made on diseased sinuses. First, one must make sure that definite sinus disease exists, that it is the cause of asthma and that the lesion cannot be controlled by a preliminary course of vaccine therapy. If, after a period of careful observation and conservative treatment, satisfactory results are not secured, then recourse must be had to sinus surgery; and I wish to make a few comments on sinus surgery because of a general disrepute into which it has fallen among physicians as well as the laity. Frankly I believe in it, because I have experienced and witnessed its benefits in persistent and even intractable asthma, and when properly indicated, the earlier the surgery is done the better the result on the asthmatic patient. My comments may be summarized as follows: (1) Rarely is surgery indicated under 25 years of age. (2) In patients allergic to inhalant and food substances, avoidance of or treatment with the allergen should always be practised before and after surgical procedure. (3) The operation must be superlatively well done by one trained in surgical technique and with a thorough knowledge of the anatomy of the sinuses. (4) The object of sinus surgery is to remove infected tissue, leave the sinuses well open for drainage and conserve as much turbinal tissue as possible. (5) Resection of the septum is indicated only when there is interference with the surgical approach to the ethmoid and sphenoid cells or a complete blocking of a nasal cavity. (6) One trouble with sinus surgery generally is that when indicated it is done in piecemeal fashion and not completely enough or it is done too late. (7) The cases must be carefully selected on the basis of their physical condition. One should not expect satisfactory results in old long-standing cases with extensive pulmonary

fibrosis. (8) The results of sinus surgery in patients with asthma operated on by Dr. Grove in our clinic were obtained by continuous follow-up study. Since we are only interested in the end results and not an immediate temporary effect, I am presenting the figures of the 2 to 8 year post-operative group. In 74 cases all indicated surgery had been done. In 78 cases, for one reason or another, it was not, and they form a good control group. In the first group 8 per cent were not improved, 40 per cent showed definite improvement and 52 per cent were having little or no asthma. In the 78 cases in whom surgery was not completed, 64 per cent were not improved, 23 per cent showed definite improvement and only 13 per cent were having slight or no asthma. These figures I believe speak for themselves, and in my experience there is no therapeutic procedure to equal it today, for in these patients the usual course is relentlessly onward to complete disability for years, with an exitus due to asthma itself or some complication directly or indirectly connected with it. (9) Finally, to secure these good results, a long postoperative convalescent period must be insisted upon. Remember that in this operation only the primary focus is removed. The secondary infections in lung, bronchi and hilum glands require time for healing to take place. Rest, food and medical care are important in the convalescent period, which may be only three months, perhaps six months, and in some cases should be a year. I want to impress upon you my feeling of the importance of this convalescent period which is just as necessary to these patients as it is to those with tuberculosis.

It has not been possible for me to attempt to cover the field of allergy with its manifold variations and evidences involving nose, chest, abdomen, brain and skin. I have merely pointed out in a general way the importance of allergy as a health problem, some of the fundamentals of what we mean by allergy and particularly I have stressed the significance of the important respiratory allergies and have tried to convey my conviction that much more could and should be done with these cases by prompt and early recognition of the fact that they may be prevented and can be controlled if properly approached for an etiological diagnosis in the earliest stages of disease.

CLOSING THE DOCTOR'S MOUTH
ON THE WITNESS STAND¹

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Physicians and surgeons are required by the ethics of their profession to preserve the secrets of their patients which have been communicated to them or learned from the inspection of symptoms and other bodily conditions. How far this ethical requirement should be enforced by law is a question on which there is much difference of opinion among both lawyers and doctors.

No state has made disclosure of confidence a crime, as it is in France, but in some the license to practice may be revoked for this cause. About fifteen states still preserve the view of the English common law that there is no legal check upon the betrayal of secrets except a possible liability to the patient for damages. This has been settled law in Rhode Island since Dr. Fenner H. Peckham was allowed to testify in a divorce case nearly forty years ago.²

The remaining states adopt a half-way attitude towards the obligation of secrecy, of which the New York statute (first enacted in 1828) is typical. Unless the patient consents, the doctor is not allowed, while testifying in court, "to disclose any information which he acquired in attending a patient in a professional capacity and which was necessary to enable him to act in that capacity." Thus there is no liability to the patient if the doctor tells every last detail in clubroom gossip or the thickly veiled items of a medical journal, but he is prohibited from divulging any of the truth in the place where it is most needed and usually most stringently required — the witness stand.

The general policy of the law is to obtain as many facts as possible about a controversy on trial, but this policy is cut into at many points by what are called rules of evidence. For instance, a witness cannot tell what he has learned from hearsay and not from his own observation, because such testimony is likely to be untrustworthy. The physician's evidence would be free from this objection, but the law often keeps out reliable testimony if it was acquired by the witness through some confidential

relation. Thus a husband would hesitate to tell his wife about damaging facts and the thorough intimacy of marriage would be turned into watchful suspicion and reticence, if the law did not refuse to make her the means of his undoing.³ Likewise a man might not consult an honest lawyer, or if he did, would tend to keep back from him anything that looked unfavorable to the case, if the lawyer could be made the leading witness against him and forced to reveal all that was told him by his client. So the lawyer cannot speak without his client's consent.⁴ In many states, though not in Rhode Island, a statute protects the secrets of the confessional; and even without such legislation few lawyers would have the hardihood to ask that a priest who keeps silent should be imprisoned for contempt of court.

Some doctors may feel that the Rhode Island law discriminates unfairly against their profession. If lawyers' secrets are protected from disclosure in court, why not physicians' secrets too? Yet one could turn this argument for equal treatment the other way round, and deny protection in both cases. Perhaps lawyers like doctors should be forced to divulge information when the judge thinks disclosure essential to the public interest. Jeremy Bentham became white-hot against the inviolable secrecy of communications between attorney and client: "Whence all this dread of the truth? Whence comes it that anyone loves darkness better than light, except it be that his deeds are evil?"

Nevertheless, there is much to be said in favor of the attorney-and-client privilege,⁵ and most lawyers, at any rate, are convinced that it should be retained. However this may be, the situation does differ from that of physician and patient, as I shall indicate later. For the present I am interested in the question whether medical secrets should be inviolable in court. Proposals may be made for the adoption of the New York statute, or something of the sort, in Rhode Island. Should doctors support such legislation?

The reasons usually advanced for extending the privilege of silence to the medical profession are not wholly satisfactory. First, it is said that if the patient knows that his confidences may be divulged in future litigation he will hesitate in many cases to get needed medical aid. But although the man who consults a lawyer usually has litigation in mind,

men go very rarely to a doctor with any such thought. And even if they did, medical treatment is so valuable that few would lose it to prevent facts from coming to light in court. Indeed, it may be doubted whether, except for a small range of disgraceful or peculiarly private matters, patients worry much about having a doctor keep their private affairs concealed from the world. Usually the patients themselves bore their casual acquaintances with full details for an operation or a disease. And when they do dread disclosure of their physical condition by a doctor, their fear is not that the truth may some day be forced from him in court, but that he may voluntarily spread the facts among his friends and theirs in conversation; and against this really dangerous possibility the New York law gives the patient no protection. This whole argument that the privilege is necessary to induce persons to see a doctor sounds like a philosopher's speculation on how men may logically be expected to behave rather than on observation of the way they actually do. Not a single New England state allows the doctor to keep silent on the witness stand. Is there any evidence that any ill or injured person in Rhode Island or the rest of New England has ever stayed away from a doctor's office on that account?

The same *a priori* quality vitiates a second argument of the framers of the New York statute about the evils of compelling medical testimony: "During the struggle between legal duty on the one hand and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will in most cases furnish a temptation to the perversion or concealment of the truth, too strong for human resistance." Has any member of the Rhode Island Medical Society observed such a tendency among Rhode Island doctors to commit perjury for the sake of "professional honor?"

There is far more danger of perjury if the physician cannot testify, only it will be perjury by the patient. In many states where the privilege exists, an unscrupulous plaintiff in an accident case can exaggerate the injury without fear of contradiction by the doctor whom he consulted right after the accident. The patient can tell the sad story of his injuries to judge, jury, and spectators, and then he can object that it would violate his bodily privacy if the doctor were allowed to take the stand and

testify that the accident had left no traces one hour after it occurred. Fortunately, there is some limit to this absurdity. Most courts hold that if the patient goes into the details of his injuries, then he has waived his privilege; he has thrown open the whole question of his bodily conditions.⁶ Otherwise he could make the statute both a sword and a shield.

Yet this rule about waiver does not promote truth-telling any too well. The patient may tell some rather big lies about his health without "going into details," and the courts are by no means clear in defining the point where details begin. There is also abundant confusion on the question whether what the patient says under cross-examination opens the door for his doctor to testify. Some courts hold that cross-examination is not a waiver like direct testimony, because the patient does not now speak willingly. By this view, the opposing lawyer who ventures to ask the patient any questions may find the witness going into the most intimate details without regard to either privacy or truth, and yet the lawyer will be helpless to contradict this highly colored story by calling the physician.

The absurdity of this solicitude for the patient's privacy is illustrated by a recent Ohio case.⁷ The plaintiff sued the owner of a building for heavy damages, charging that the defendant negligently suspended a fire hose from the building in such a manner that a violent wind caused the hose to break a window, knocking glass against the plaintiff. He testified that since this accident he had suffered loss of weight, severe and chronic headaches, failing eyesight, insomnia, facial paralysis, and inability to walk normally; but that before the glass hit him his general physical condition was "very good." On cross-examination he admitted that he had consulted various physicians before the accident. The defendant called one of these doctors for the purpose of showing that the plaintiff was suffering from anemia before the accident. The court refused to allow the doctor's evidence "in view of the very delicate and confidential nature of the relation."

Another argument for the privilege is that employees are often treated after accidents by physicians who are in charge of the company hospital or otherwise dependent upon the good will of the employing corporation. It was urged to legislatures

that some of these physicians were taking advantage of their position to obtain from the patients information which would tend to defeat a claim for damages. This argument has the merit of not being abstract, but of claiming a basis in fact. Even if true, it might be wiser to admit the evidence of the physicians, trusting in the jury to discount it heavily if an improper attitude towards the patients existed.

Where the statutory privilege is in force, what is its scope? In the first place, what sort of medical person is included?⁸ Any licensed physician or surgeon falls within the statute, and this applies to hospital physicians though they are not specifically selected by the patient.⁹ There is no privilege for communications to unlicensed practitioners. Thus mental healers, chiropractors and osteopaths can be forced to disclose communications from their patients, unless perhaps their professional status is expressly recognized by law. How about the numerous assistants who surround doctors under modern conditions? Many attempts have been made to prevent nurses from telling about their patients, but these have usually failed.¹⁰ Most courts say that if public policy demands the extension of the privilege to nurses and other hospital attendants, then the change in the law should be made by the legislature, not by judicial action. Here is an enticing invitation to organizations of nurses to increase their professional prestige by lobbying for a statutory amendment which will put them on the same high level of secrecy as doctors. This result has already been accomplished in New York and a few other states. Dentists may also resent being left out in the cold with druggists. And the privilege does not apply to an unlicensed "orthopedist" who is teaching gymnastic exercises taken by medical advice.¹¹ Those psychoanalysts who have been too busy to study medicine must have spicier facts to relate than physicians, but no court has yet bound them to secrecy. The status of veterinaries was raised in an Iowa suit brought by the owner of a race horse against the Western Union for delay in transmitting a telegram, "Bravo is sick; come at once." The doctor arrived at last, but Bravo died. The Western Union lawyer asked the doctor what the owner said to him about Bravo's symptoms. The owner urged that the communications from Bravo to the veterinary were privileged, but the

court held that veterinaries were not covered by the statute.¹²

No end of trouble has arisen about the admissibility of medical records. If a doctor cannot tell the court what he saw, then the hospital records where he wrote down what he saw seem logically just as unavailable. Yet some courts are impressed by the fact that the law requires such records to be kept, and see little sense in this if they cannot be used for the sake of attaining justice.¹³ For example, it would be absurd if the records of a state hospital for the insane could not be consulted in a will contest for their bearing on the mental capacity of the testator.¹⁴ So judges have been inclined to read a wide exception into the statute to cover such situations. Thus death certificates ought to be admissible.¹⁵ In New York this exception has been extended to public health records, which were admitted to show that the defendant was a typhoid carrier who had been warned not to participate in the service of food. The records were used to establish her liability in damages to the estate of a man who died of typhoid after eating food which had passed through her hands.¹⁶

How about autopsies? It is generally held that if the doctor had not attended the person during his lifetime, then the doctor can testify about performing an autopsy because the relation of the physician and patient did not exist.¹⁷ "A deceased body is not a patient."¹⁸ For example, a man who carried heavy accident insurance became suddenly ill. The physician who was called removed him to a hospital and there continued to treat him until his death. The hospital pathologist was then summoned to perform an autopsy, which showed that the man died from the effect of wood alcohol in home-made gin. The first doctor was merely allowed to give his opinion that wood alcohol in gin was capable of causing the death, but the second doctor was permitted to give all the details discovered during the autopsy.¹⁹ However, another court regarded this device of getting away from the privilege by switching doctors as an arrant subterfuge and ruled out the autopsy by asking:

"Can a hospital, immediately after the death of one of its patients, discharge the physician who had attended the patient up to the time of death, and thereafter rush the dead body to the morgue, and direct the physician at the head of the pathological

department to perform an autopsy, and thus evade the statute which sealed the lips of the first physician? We think these questions should be answered in the negative, and that a physician under such circumstances steps into the shoes of the attending physician, and must be treated as if he were the assistant of the attending physician, holding the autopsy at the direction of the latter, and that the information acquired by him through the autopsy is privileged."²⁰

The question what part of the physician's knowledge about the patient is non-professional raises great difficulties. The fact that he was ill, the number of visits made, the performance of an operation at a certain date may be disclosed, but not the nature of the illness or the operation. It would seem that symptoms which were obvious to every one without medical inspection cannot be said to be disclosed in confidence, but several cases have forbidden hospital doctors to testify that when a man was brought in they smelled liquor on his breath or observed other common symptoms of intoxication.²¹

The information must be received in a professional relation; not everything medical which a doctor sees or hears is privileged. For example, if called to a house to see a person, the doctor can sometimes tell what he incidentally observed as to the health of other members of the family.²² If the patient voluntarily employed the physician, the privilege is clear. But suppose the doctor renders first aid to an unconscious man. No confidence is reposed, but the doctor does attend him in "a professional capacity." In a New York case a physician was called by a hotel to attend a guest without the latter's knowledge. The man said he had taken poison, but cursed the doctor and refused to have anything to do with him. The doctor administered a hypodermic. The hotel guest was held to be a patient, although he did not want to be, and the doctor was forbidden to tell about the poison in order to show that the patient had forfeited his life insurance by committing suicide.²³

Even though a professional relation exists, only information necessary to enable the doctor to act in that capacity is privileged. Matters which are entirely distinct from medical facts may be disclosed;²⁴ for instance, the patient's remarks about his will. An Indiana doctor was called to attend a sick wife and also cast a professional eye on her

husband. While leaving the house, he heard the husband say "I will get her yet, damn her; I will get her yet." Shortly afterwards the wife shot her husband. When tried for murder, she called the doctor as a witness to support her story that she killed her husband in self-defense while he was approaching her with an open knife in his hand. The trial court excluded the doctor's evidence on the ground that he was in the house in the capacity of a physician. The jury disbelieved the wife's story and she was convicted of manslaughter. The upper court reversed, holding that the doctor should have been allowed to testify about threats of death though not about health.²⁵

Oftentimes the illness and another fact are closely connected, as in a New York divorce trial which received much attention in the press twenty years ago, where a physician was asked to disclose a communication from the misguided wife as to the paternity of an expected child. The referee excluded this communication, because it must have been given as a sequel to the wife's disclosure of her pregnancy, which was clearly privileged and could not be repeated. On the other hand, a California doctor was allowed to testify that while he was delivering an illegitimate child a certain man was present and admitted that he was the father.²⁶ A similar problem arises when the victim of an accident in describing his symptoms to a physician throws in occasional statements about the way he was hurt. Of course, the speed of the trolley car which hit him and the fact that he himself was not looking as he crossed the street are not really necessary for the application of surgical dressings, and the legitimacy of an expected child has no bearing on the medicines or osteopathic treatment which should be given to the mother. (If the doctor were a psychiatrist, who was curing her of melancholia or some other mental or nervous disorder, questions on such a fact would be highly important.)

Logically, it may be that the facts leading up to a physical condition are often not "necessary to enable the physician to act in a professional capacity" and consequently are not protected by the statute. Yet practically it is very unjust to a patient, consulting a physician in a state where the law insists that the utmost confidence shall be preserved, if his conversations with the physician can be sifted out by the law into two classes of utterances and only one class is kept secret. Here comes a sentence which is

held necessary for treatment; but the next, dealing only with the cause of the ailment, receives no protection. The dividing line may fall in the middle of a sentence. What sort of confidence is secured by the statute if a sick and perhaps hysterical patient must be constantly on the alert, every time a question is asked him, to determine at his peril whether it is necessary for treatment, and, even if it is, must be watchful lest he add something to his answer which is not necessary? If the privilege is to exist at all, the law might well take the position that all the communications of the patient which are actuated by his feeling of confidence in his medical adviser and which he would naturally make in furnishing the doctor with information as a basis of treatment are entitled to secrecy, even though some of these facts if wrenched from the conversation and taken singly have no medical value. A patient should not be forced to tell his story to the doctor with the circumspection of a lawyer drawing pleadings.

The privilege belongs to the patient and not to the physician. Hence the patient cannot be forced to testify about the consultation any more than the doctor. Conversely, if the patient consents to the disclosure, the doctor can no longer insist on remaining silent. Is anything less than express consent enough? The effect of the patient's testifying about his own health has already been discussed. Suppose the plaintiff in a personal injury case, who has been to several doctors, calls only one physician who is favorable to his own claim; can the plaintiff still insist that it might cause him "embarrassment and disgrace" if the defense were allowed to put on his other doctors who are ready to tell a very different story about the plaintiff's bodily condition? As to this the cases are in great confusion.²⁷

Sometimes the patient is dead and can no longer waive his privilege. Must the doctor's lips then be sealed forever? Some statutes have neglected to provide for this emergency, while other expressly permit the executor or administrator of the patient to authorize the doctor to speak.²⁸ Yet no matter how carefully the statute be drawn, it is likely to fail to specify some person connected with the decedent who has an excellent reason for desiring the doctor's testimony. For example, in a Wisconsin case a widow suing as a beneficiary under an accident insurance policy was unable to prove that her husband's death was accidental except by the testimony

of the physician who attended him. The Wisconsin statute did not expressly say that a beneficiary could waive the privilege. Hence the court forced the doctor to keep silent, and the widow recovered nothing on the policy.²⁹ Here the privilege, which is supposed to exist for the patient's benefit, operated to defeat one of his dearest desires. Wigmore's view that nobody except the patient may take advantage of the privilege would have accomplished a just result in this case. Certainly a person directly antagonistic to the patient should not profit from the privilege. Many insurance policies endeavor to avoid such difficulties by a clause in which the insured waives the privilege in advance. Such a clause is usually held valid, but it has no effect in New York.³⁰

The possibility that the patient's death silences the doctor is particularly objectionable when the patient was murdered. It may be very important to have a physician disclose the physical condition of the victim, during the interval between the crime and the death. Sometimes a man kills a woman to get her out of the way because she is expecting a child and medical testimony is necessary to establish his motive. Judges usually get around this difficulty by saying that criminal cases are not within the spirit of the statute, although some courts refuse to carve out such an exception.³¹ Usually the desired testimony relates to the bodily condition of the victim, but it may conceivably concern that of the accused and here the bars have been higher.³² Suppose a murder on a dark street. A policeman testifies that he could not recognize the killer, but that he shot at him as he was running away and winged him in the left arm. The prosecution calls a physician for the purpose of having him testify that one hour after the murder the accused called at his office and was treated for a bullet-wound on his left arm. The accused objects on the ground that he does not want to lay his ailments bare to the public. It is by no means certain on the authorities that the doctor would be allowed to testify, and so the prisoner might be acquitted for inability to identify him with the murderer.

A similar but much more perplexing conflict of loyalties was presented to Dr. C. E. May of Minnesota. While Dillinger, the former Public Enemy No. 1, was fleeing from prison, he went to Dr. May to be treated for gunshot wounds incurred during his escape. Was Dr. May ethically bound as a phy-

sician to preserve secrecy or was he under a duty as a citizen to notify the police? In fact he neglected to inform the police of his ministrations and was consequently imprisoned two years for harboring a fugitive wanted under a federal warrant.³³ *The Lancet* commented that "colleagues in every country will applaud his action in not betraying a professional trust."³⁴ Not many laymen are likely to join in the applause.

Legislatures and courts have been occupied for over a century in closing the physician's mouth in the very place where the truth is badly needed. And yet the much more important obligation of his silence in private life has hardly been considered by the law at all. We have put our money on the wrong horse. In the few instances where honest patients do dread disclosure of their physical condition by a doctor, their fear is not that the truth may some day be forced from him in court, but that he may voluntarily spread the facts among his friends and theirs in conversation; and against this really dangerous possibility the statutes give almost no protection. The first and only decision on the doctor's liability to pay damages to his patient for a breach of confidence was made in 1920, under the common law, and recovery was denied, although a possible liability under different circumstances was suggested by the Nebraska court.³⁵

A guest of a small hotel in a Nebraska town consulted a doctor who diagnosed his ailment as syphilis. He told the patient of the danger of communication and got his promise to leave the hotel the next day. On that day the doctor made a professional call on the owner of the hotel, and on finding that the patient had not moved out he warned the owner that the man had "a contagious disease." The patient was forced to leave the hotel, and sued the doctor. Since the diagnosis was perhaps incorrect the doctor might have been liable for slander, because of the defamatory nature of his statement, although he might have raised the defense that there is no duty to pay damages for a slanderous statement if it is made honestly and on reasonable grounds in pursuance of a duty. For example, if a doctor is required by law to report certain diseases to the Board of Health, and makes such a report honestly but mistakenly, he is not liable for slander. But should he be protected if he volunteers false statements to a private person?

Suppose the doctor's diagnosis was correct, so that he told the truth to the hotel-keeper. Then he would not be liable for slander, since truth is a defense in that kind of suit. But the actual suit was not for slander; it was for violation of the physician's contractual obligation to remain silent about his patient. Can the truth be told with impunity if a confidential relation is thereby violated? The Nebraska court thought that a doctor ought to pay damages for telling the truth in breach of his duty to his patient, but that he should have the same right as a man who is sued for slander to insist that he acted under a duty to make the disclosure, which was more important than the duty to keep silent. Clearly his statutory obligation to make health reports would justify breaches of confidence therein. Here, however, he was under no legal obligation to divulge his patient's disease; but the court decided that in view of the great danger to life resulting from silence he had a moral obligation to speak which overrode his duty of secrecy. Consequently, the patient lost his case.

Much can be said for and against this result. One commentator says that the Nebraska case "stands for the triumph of medical altruism over legal duty." Certainly, disclosure of risks of infection is very desirable; but it would be wiser to require all contagious diseases to be reported to a public official, who should have power to take all steps necessary to protect people from the patient, whether this required publicity or his removal to a hospital. There are obvious dangers in leaving it to every physician to determine whether circumstances justify him in betraying intimate confidences.

In conclusion, the law would seem to have directed its attention to the wrong quarter in laying so much emphasis on silence in the court and neglecting until now the patient's rights against disclosures to the world in general.

1. Much of the material in this paper was used by the author in an article in the old *New York Evening Post*, July 2, 1921, and in part of an article in 35 *Harvard Law Review* 689-691 (1922). In revising the material for republication, the author has been greatly aided by the classic discussion in 8 *Wigmore on Evidence* (3d ed. 1940) §§ 2380-2391. See also 152 *Law Times* 53 (1921), debates at British Medical Association; 153 *Law Times* 228, 252 (1922), debates at British Medico-Legal Society; 83 *Law Journal* 320 (1937), debates in House of Commons.
2. *Banigan v. Banigan*, 26 R. I. 454, 59 Atl. 313 (1904); followed in *Remington v. Rhode Island Co.*, 37 R. I. 393, 93 Atl. 33 (1915) (accident).

3. R. I. General Laws (1938), c. 537 §15: "neither [husband nor wife] shall be permitted . . . to disclose any communication made to him or her, by the other, during their marriage," except in a few specified types of litigation. See *Campbell v. Chace*, 12 R. I. 333 (1879); *State v. Deslovers*, 40 R. I. 89, 110, 100 Atl. 64 (1917); *Parenteau v. Parenteau*, 51 R. I. 263, 265, 153 Atl. 872 (1931); *Bradley v. Quinn*, 53 R. I. 349, 166 Atl. 814 (1933).
4. Although no Rhode Island case has been found, the rule is solidly established by numerous English and American decisions.
5. The arguments are given at length by Wigmore, §2291.
6. The cases are collected in 114 American Law Reports Annotated 798 (1938). (This series will be hereafter cited as A.L.R.) See also Wigmore, §2389.
7. *Harpman v. Devine*, 133 Oh. St. 1, 10 N. E. (2d) 776 (1937), discussed in 11 U. Cinc. L. Rev. 544.
8. The cases are collected in 68 A.L.R. 176 (1930); Wigmore, §2382.
9. The cases are collected in 22 A.L.R. 1217 (1923); 72 U.S.L. Rev. 619 (1938).
10. The cases are collected in 39 A.L.R. 1421 (1925); 68 A.L.R. 177 (1930). On hospital attendants, see 22 *Marquette L. Rev.* 211 (1938).
11. *Laurie Co. v. McCullough*, 174 Ind. 477, 19 N. E. 1014 (1909).
12. *Hendershot v. Western Union Telegram Co.*, 106 Iowa 529, 76 N. W. 828 (1898).
13. The cases are collected in 75 A.L.R. 393 (1931); 120 A.L.R. 1140 (1939).
14. *Liske v. Liske*, 135 N. Y. Supp. 176 (1912).
15. Yet some courts excluded them. See the authorities in Wigmore, §2385a; 17 A.L.R. 370 (1922); 42 A.L.R. 1455 (1926); 96 A.L.R. 341 (1935).
16. *Thomas v. Morris*, 286 N. Y. 266, 36 N. E. (2d) 141 (1941), annotated in 136 A.L.R. 856.
17. The cases are collected in 58 A.L.R. 1134 (1929); 35 *Law Notes (N. Y.)* 87 (1931).
18. See case cited in note 19 *infra*.
19. *Travelers' Ins. Co. v. Bergeron*, 25 F. (2d) 680 (C.C.A. 8th, 1928).
20. *Matthews v. Rex Health and Ins. Co.*, 86 Ind. App. 335, 157 N. E. 467 (1927).
21. The cases are collected in 79 A.L.R. 1131 (1932).
22. *Jennings v. Supreme Council*, 81 N. Y. App. Div. 76, 81 N. Y. Supp. 90 (1903). See *Nichols v. State*, 109 Neb. 335, 191 N. W. 333 (1922).
23. *Meyer v. Knights of Pythias*, 178 N. Y. 63 (1904).
24. The cases are collected in 24 A.L.R. 1202 (1923); Wigmore, §2383; 13 *Wash. L. Rev.* 141 (1938).
25. *Myers v. State*, 192 Ind. 542, 137 N. E. 547 (1922).
26. *Baird's Estate*, 173 Cal. 617, 160 Pac. 1078 (1916).
27. 62 A.L.R. 680 (1929); 90 A.L.R. 646 (1934); 51 *Harv. L. Rev.* 1931 (1938); 31 *Yale L. J.* 529 (1922).
28. The cases are collected in 31 A.L.R. 167 (1924); 126 A.L.R. 380 (1940); Wigmore, §2391.
29. *Maine v. Maryland Casualty Co.*, 172 Wis. 350, 178 N. W. 749 (1920), two judges dissenting; annotated in 15 A.L.R. 1544.
30. The cases are collected in 54 A.L.R. 412 (1928); Wigmore, §7a.
31. The cases are collected in 45 A.L.R. 1357 (1926); Wigmore, §2385.
32. *People v. Murphy*, 101 N. Y. 126 (1885).
33. 32 *Mich. L. Rev.* 1164 (1934).
34. 226 *Lancet* 1183 (June 2, 1934).
35. *Simonsen v. Swenson*, 104 Neb. 224, 177 N. W. 831 (1920), annotated in 9 A.L.R. 1254, 20 *Col. L. Rev.* 890, 34 *Harv. L. Rev.* 312, 30 *Yale L. J.* 289, 75 *J. Am. Med. Assn.* 1207. See also *Smith v. Driscoll*, 94 *Wash.* 441, 162 *Pac.* 572 (1917).



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It is just as much the duty of an authority on a subject to condense, summarize and analyze his contributions for the sake of his less learned readers as it is to increase the store of knowledge.

Northagel once said that the greatest scientific contributions to medicine seldom covered more than a few pages. Or as Billings put it, "First have something to say, say it as briefly as possible and stop when you have said it".

Wilbert C. Davison,
Bulletin History of Medicine.

ARE YOU UNDER 45?

In the May 1942 issue of the RHODE ISLAND MEDICAL JOURNAL appeared an editorial giving a synopsis of the changes in the method of commissioning medical officers in the Army of the United States.

Briefly, the Medical Officers Recruiting Board opened an office in the basement of the Rhode Island Medical Library Building for the purpose of accepting applications, authorizing physical ex-

aminations, and commissioning properly qualified doctors, dentists, and veterinarians in the grades of lieutenant and captain, whose names had been made available by the State Procurement and Assignment Agency.

When the Recruiting Board receives the name of a doctor who has been made available, a letter is mailed inviting the doctor to visit the Recruiting Office. During that visit the Board explains the need of medical officers in the armed forces, and offers to help an applicant in preparing the papers necessary for granting a commission. By well defined regulations the Recruiting Board has the authority to commission first lieutenants and captains in the Medical Corps. All other applications may be received by the Recruiting Board, but they must be referred to the Office of the Surgeon General for disposition.

One of the chief reasons for opening a branch of the Surgeon General's Office in each state is to decrease the time required to commission an applicant, and to increase thereby the number of medical officers in the armed forces. Since many doctors had apparently thought that enrollment with the Procurement and Assignment Agency was an application to enlist, they had done nothing further. The number entering the Medical Corps has not kept pace with the expansion of the other branches of the Service. To be commissioned, a doctor must voluntarily apply.

The need of Medical Officers has been stressed by too many government officials including Mr. McNutt to be questioned. The time element now is very important. To be of the most use a medical officer needs a certain amount of training—time to familiarize himself with the methods and routine of military life, without which his efficiency is greatly impaired. Doctors below the age of forty-five are urgently requested to join immediately. No one man's problems or group of men's problems can be greater than those of his Country.

REFUGEE PHYSICIANS

As the demand for physicians to serve with the armed forces is greatly depleting the number of doctors in civil practice, it is fortunate that a large group of physicians have entered this country as refugees from Europe. In spite of the fact that

in many states, Rhode Island included, these men are, according to existing rules, debarred from entering private practice, their presence will probably prove of great benefit to the public. This can be brought about in at least two ways: by placing them in hospitals and other institutions to replace staff members who are in service; and by admitting them to some type of limited practice in communities where the need is great. Already in Rhode Island the first of these methods of utilizing the help of our new colleagues is being planned and the Governor's intention to suspend the Civil Service regulations for the emergency to allow for the use of these men in our State Institutions has been upheld by the resolution recently passed by the House of Delegates of the State Society.

Although certain members of the profession have expressed a fear that some of these doctors from abroad, by virtue of the emergency need for their services, may become established in practice to the detriment of native physicians who are serving with the armed forces, such fear is neither justified nor creditable. If the placement of such physicians is restricted to areas where a real need exists the public will be benefited and no harm will be done.

In this connection it may be pointed out that these physicians come either from countries invaded by Hitler or have been expelled from Germany itself by the Nazis. In either case they are our allies in this war and should be treated as such. Many of them are distinguished members of the profession who have held professorial and other responsible positions in their own countries and represent a welcome addition to our ranks. They are as a group qualifying as quickly as the law allows for American citizenship and many will enter the armed forces as soon as possible under the regulations. One other consideration is significant. At the end of this war the demand for physicians for rehabilitation of medical service in war torn countries will be tremendous.

It is therefore to the advantage of all concerned to welcome these colleagues to our ranks and, rejecting all petty considerations as to possible infringement upon the field of private practice, to arrange for them to help where help is needed, for after all the good of the public must be paramount and any selfish attempt on the part of the profession to play the dog in the manger is unworthy.

ONE HUNDRED AND FIFTIETH MEETING OF CONNECTICUT SOCIETY.

The Connecticut State Medical Society celebrated its one hundred and fiftieth annual meeting at Middletown on June 3rd and 4th, 1942. The event was a decided milestone in the history of the fourth State Medical Society to be organized in this country, although as a matter of fact, the Connecticut Society is the *third* oldest in the point of view of continuous existence. The meetings this year were held on the campus of Wesleyan University. An historical atmosphere permeated all the gatherings. An interesting, commemorative volume tracing the history of medicine in Connecticut was published coincident with the anniversary, and an outstanding historical exhibit of documents, pictures, instruments, and other demonstrations going back a hundred and fifty years was on display at the University library. An entire morning was devoted to historical papers, and throughout the two days many distinguished guests contributed to the presentations. The meetings culminated with an address at the annual banquet by Colonel Fred W. Rankin, M.C., U. S. Army, President-elect of the American Medical Association.

The Rhode Island Medical Society was honored by having two of its members present papers by invitation during the scientific session on June 3rd. Dr. Albert H. Miller of Providence addressed the section on anesthesia with a paper on "New England—The Cradle of Anesthesia in America." Dr. Charles Bradley of East Providence addressed the Hezekiah Beardsley Pediatric Society, which convenes as the section on pediatrics of these annual meetings, with a paper entitled, "Diagnostic and Therapeutic Aspects of the Problem of Behavior Disorders in Children."

The RHODE ISLAND MEDICAL JOURNAL is happy to convey to the State Medical Society of our sister state the greetings and congratulations of all Rhode Island physicians as this milestone of medical progress passes into history.

ANNUAL MEETING LARGELY ATTENDED.

The 1942 meeting of the Rhode Island Medical Society held in Providence June 3rd and 4th enjoyed the largest attendance in recent years. Registrations for the scientific sessions at the Medical

Library totaled two hundred and sixteen members of the Society, forty-seven physicians who are not members of the Society, and thirty-nine other guests or a total of three hundred and two. The annual dinner held at the Agawam Hunt Club on the evening of June 4th was attended by two hundred and forty-seven members and guests, which is a greater attendance than at any meeting within recent years. High spots of the 1942 meeting were the usual hospital clinics on the mornings of both days, a less crowded program of scientific papers in the afternoon than on previous occasions, a reception for members and guests at the Agawam Hunt Club in the late afternoon of June 3rd, and the annual dinner with conspicuously timely and interesting addresses by members and guests. The commercial exhibits, which were held for the first time in the basement floor of the Medical Library, had a good registration, and exhibitors, whose good will and enthusiasm do much to vitalize our annual meetings, were all well satisfied. This unusually well-attended meeting in the first year of the present war speaks well for the enthusiasm and increasing support of the State Society's activities, and is particularly gratifying to the officers and committee members whose energy promotes these meetings.

RHODE ISLAND MEDICAL SOCIETY

HOUSE OF DELEGATES

Special Meeting

A special meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library June 19, 1942 at 8 P. M. The President, Dr. Charles F. Gormly, was in the Chair.

Dr. Gormly stated that there was an acute shortage of resident physicians at the State Hospital for Mental Diseases, the Exeter School and, possibly, other State Institutions; that the Governor wished to appoint alien physicians to these positions but before doing so wished to have the approval of the Rhode Island Medical Society.

The Secretary read letters from the Caduceus Club and the Pawtucket Medical Association approving the appointment of alien physicians if this is essential to the welfare of our citizenry, provided that such service should not qualify the aforementioned refugee physicians as eligible for licensure in this State.

Dr. Gormly read several letters from individual physicians protesting against such appointments. After discussion by several members, Dr. Alex M. Burgess introduced the following resolution:—

"Be it resolved that the House of Delegates of the Rhode Island Medical Society at a special meeting this day, June 19th, 1942, approves the employing of alien physicians, not licensed in the State of Rhode Island, by the State Institutions.

"Be it further resolved, that the Rhode Island Medical Society approves the suspension by the Governor, of the Civil Service regulation requiring citizenship by all employees of the State Institutions, as an emergency war measure, and as it relates to the so called alien physicians."

After discussion, the motion as introduced by Dr. Burgess was adopted.

The Secretary was instructed by the President to send a copy of the Resolution to the Governor, the Director of Social Welfare and the Superintendent of the State Hospital for Mental Diseases.

Dr. Gormly then told the House of Delegates about recent bills in Congress regarding osteopaths in the armed forces. The Secretary read excerpts from a communication from the Legal Department of the American Medical Association which explained that the bill to authorize commissions in the armed forces of osteopaths had been rejected by the Senate. The bill authorizing the employment of osteopaths as internes had passed and was now law although no osteopaths had yet been employed.

A Resolution was passed:—

"The House of Delegates of the Rhode Island Medical Society goes on record as being opposed to the lowering of standards of licensure for physicians in Rhode Island."

There being no other business to come before the House, the meeting adjourned at 10 P. M.

Respectfully submitted,

WILLIAM P. BUFFUM, *Secretary*.

COMMITTEE ON EDUCATION

The fifteen-minute radio talks which have now been running continuously since December 1938, over Station WPRO every Sunday afternoon at 1:30 p. m., have been continued without letup, and it is apparent from the many letters and requests for copies of talks that our audience is a growing and enthusiastic one. Forty-seven radio talks have

been given in the past year of which the following is a list:

119. May 11 Blue Cross Program
120. May 18 Sub-acute Bacterial Endocarditis
Dr. A. Henry Fox, Riverside, R. I.
121. May 25 The Training of a Nurse
Miss Edna G. Myers, Providence, R. I.
122. June 1 Electrocardiography
Dr. Frank B. Cutts, Providence, R. I.
123. June 8 Foods and the National Emergency
Dr. William L. Leet, Providence, R. I.
124. June 15 Sinusitis
Dr. Frank L. Burns, Providence, R. I.
125. June 22 Medical Lessons Learned from the Selective Service Act
Major Lloyd C. Wilson, Providence, R. I.
126. June 29 The Changing Aspect of Military Medicine
Major Harold I. Rogell, Fort Getty, R. I.
127. July 6 Tumors of the Skin
Dr. William B. Cohen, Providence, R. I.
128. July 13 The Role of the Woman Physician
Dr. Kathleen M. Barr, Providence, R. I.
129. July 20 Recent Advances in Obstetrics
Dr. George E. Bowles, Providence, R. I.
130. July 27 Typhoid Fever
Dr. Duncan Ferguson, Jr., Pawtucket, R. I.
131. Aug. 3 Recent Advances in Allergy
Dr. William S. Fain, Providence, R. I.
132. Aug. 10 Infections of the Hand
Dr. Anthony Corvese, Providence, R. I.
133. Aug. 17 Arthritis
Dr. S. J. P. Turco, Peacedale, R. I.
134. Aug. 24 The Spleen
Dr. Howard W. Umstead, Pawtucket, R. I.
135. Aug. 31 Recent Advances in Fracture Treatment
Dr. Henry McCusker, Providence, R. I.
136. Sept. 7 Psychiatry—A Brief Scrutiny
Dr. Hugh E. Kiene, Providence, R. I.
137. Sept. 14 The General Physical Examination
Dr. Alex M. Burgess, Providence, R. I.
138. Sept. 21 Surgery in the Navy
Commander William A. Stoops, Newport, R. I.
139. Oct. 5 The Modern Conception of Heart Disease
Dr. F. B. Agnelli, Westerly, R. I.
140. Oct. 12 The Nurse in National Defense
Sarah Hall, R.N., Providence, R. I.
141. Oct. 19 Surgery of Infancy and Childhood
Dr. Henry B. Moor, Providence, R. I.
142. Nov. 2 The Importance of X-ray in Medicine
Dr. William J. Butler, Pawtucket, R. I.
143. Nov. 9 Diabetes
Dr. Rawser P. Crank, Auburn, R. I.
144. Nov. 30 Tuberculosis Today
Dr. John C. Ham, Providence, R. I.
145. Dec. 7 Defend Hearing
Dr. Frank M. Adams, Providence, R. I.
146. Dec. 14 Arteriosclerosis
Dr. William P. D'Ugo, Providence, R. I.
147. Dec. 21 Bombs and Children
Dr. Charles Bradley, East Providence, R. I.
148. Dec. 28 Adult Heart Disease
Dr. Alex M. Burgess, Jr., Providence, R. I.
149. Jan. 4 The Blue Cross Today
Mr. Stanley H. Saunders, Providence, R. I.

150. Jan. 11 Pneumonia
Dr. Samuel D. Clark, Bristol, R. I.
151. Jan. 18 The Care of Your Child in Winter
Dr. Reginald A. Allen, Providence, R. I.
152. Feb. 8 The Cancer Problem
Dr. Herman C. Pitts, Providence, R. I.
153. Feb. 15 The Crippled Child
Dr. William A. Horan, Providence, R. I.
154. Feb. 22 Burns
Dr. S. J. Goldowsky, Providence, R. I.
155. Mar. 1 Conditions Confused as Diabetes
Dr. Irving A. Beck, Providence, R. I.
156. Mar. 8 The Red Cross Motor Corps
Lieut. Helen Stuart
157. Mar. 15 Oxygen Therapy
Dr. Meyer Saklad, Providence, R. I.
158. Mar. 22 The Sulfonamide Drugs
Dr. P. I. O'Rourke, Providence, R. I.
159. Mar. 29 Drug Addiction
Dr. Thad Krolicki, Pawtucket, R. I.
160. Apr. 5 Recent Advances in Surgery of the Stomach
Dr. R. D. Richardson, Providence, R. I.
161. Apr. 12 Medicine and Civilian Defense
Dr. J. C. O'Connell, Providence, R. I.
162. Apr. 19 Nervous Indigestion
Dr. Samuel Morein, Providence, R. I.
163. Apr. 26 The Importance of Health to Boys and Girls
Dr. Henry E. Utter, Providence, R. I.
164. May 3 High Blood Pressure
Dr. Clifton B. Leech, Providence, R. I.
165. May 10 The Gall Bladder—Its Diseases and Treatment
Dr. John E. Ruisi, Westerly, R. I.

3,418 letters have been received by your committee from the general public requesting copies of these talks and this same number have been mimeographed and mailed to the radio audience. There are seven who call for a copy of each lecture. This regular mailing list includes Miss Macdonald at the Public Health Library; Mr. Chapman from the Y.M.C.A.; Mr. Bartley from the R. I. Pharmaceutical Society; and Mr. Dunham from the Red Cross. Many of the letters received contain not only requests but expressions of appreciation.

It is the belief of your committee that these radio talks should again be continued as in the past. We wish to express our thanks to Miss Dickerman and her associates and to Mr. John Farrell, Executive Secretary of the Providence District Society, for the work and assistance which they have rendered to the committee. We wish also to express our thanks to Station WPRO for its courtesy in giving us time, to Blanding & Blanding, Inc. for the advertising which has been freely contributed, and to the many members of the profession who have by their cooperation and suggestions been of invaluable aid.

Respectfully submitted,
JESSE P. EDDY, 3RD, M.D., *Chairman*.

CLINICAL-PATHOLOGIC CONFERENCES OF THE RHODE ISLAND HOSPITAL

DR. B. EARL CLARKE, *Editor*

CASE RECORDS AS USED IN THE BI-WEEKLY OPEN MEETINGS.

Case presented by DR. KENNETH G. BURTON

R. C. a 5½ year old, white, male, native child of French extraction, admitted to the R. I. H. August 7, 1940 and discharged against advice Oct. 1, 1940. C. C.: Left arm painful.

P. I.: This child was admitted to this hospital on the recommendation of the Orthopedic O. P. D. clinic for a biopsy of the left arm. The history states that he was well until three months before, when he fell and sustained a fracture of the left humerus. X-rays were said to show a fracture through an area of abnormal bone. We do not know where the child was treated, nor have we access to those x-rays. The arm was supported in a sling and there was no other treatment. He continued to have pain and disability and was brought to the O. P. D. clinic.

X-ray was taken on July 30, 1940 and was reported as follows: Exam. of the lt. shoulder region shows a multilocular cystic area in the upper one-third of the shaft of the humerus extending to the epiphyseal line. There is a definite break in the cortex of the outer portion of the humerus about one inch below the epiphyseal line due to an incomplete pathological fracture. Findings simulate a benign giant cell tumor. Would advise further study including biopsy as malignant bone tumor cannot be definitely excluded. He was referred to the house for biopsy.

After admission, additional history of the P. I. was revealed by a letter from the Children's Hospital of Boston which stated that the child had been seen in that hospital on May 7, 1940 with a history of a fracture of the left upper arm, one year previously, and with obvious deformity of the upper end of the arm and evidence of non-union. Patient was placed on their waiting list but never returned. They had no x-rays. This is contradictory to the history given to us, but is probably highly important.

P. H.: Appendectomy — otherwise negative or unreliable.

F. H.: Not stated.

Review of Systems: Stated as negative.

P. E.: On admission revealed the following positive findings: T 99, P 98, R 24. A well developed and well nourished, white, male child with left arm in a sling. Tonsils hypertrophied and cryptic. Faint apical systolic murmur. Well healed right lower quadrant scar. Swelling and induration of tissues about upper end of left humerus and over shoulder. Active and passive motion guarded and limited. On abduction the scapula rotated with the arm. A different examiner stated that "Examination of the left shoulder shows no abnormal appearance of the general contour of the joint—slight deltoid atrophy—all motions of the shoulder are weak and moderately painful. The upper end of the humerus through the soft tissues is felt swollen. No enlarged glands. No neurological or circulatory disturbance evident".

Laboratory Findings: The urine examined on numerous occasions was negative. Repeated throat cultures showed hemolytic streptococcus. On August 8th and August 21st the Wasserman and Hinton were negative. August 8th—Hg. 84%; RBC 4,260,000; WBC 13,750; Polys 88; Smear normal.

Aug. 8th—Urea 11; Glucose 81; Calcium 8.9; Phosphorus 4.2. Sept. 4th—Smear from left humerus (at biopsy) showed no pus or organisms. Culture from left humerus (at biopsy) was sterile.

X-ray Reports: August 21, 1940—In comparison with the previous films, there appears to be some new bone formation at the outer end of the cortex beneath the deltoid muscle. The process has extended and involves the epiphyseal head.

September 10, 1940: The chest shows no evidence of metastatic disease or other abnormalities.

Progress: August 9th—Fever of 101. Throat cultures show hemolytic strep and patient was barriered.

His fever subsided in a few days except for frequent rise to 99, although he continued to have positive throat cultures.

He received prontosil gr. V every four hours from Aug. 29th to Sept. 4th, but the positive cultures persisted.

Sept. 4th—Biopsy of left humerus. Postopera-

tive course was apparently uneventful. He had frequent rise of temperature to 99 or 99.5.

Oct. 1st—Discharged against advice.

The diagnosis in this case is largely a question of X-ray interpretation, and, of course, the histological examination of the biopsy specimen. The history is of little help and is contradictory. In spite of the history given at our hospital, we must accept the fact that the child had something the matter with his arm as far back as sometime in 1939. According to the note from the Children's Hospital, he had deformity and non-union in May, 1940, and his symptoms were then a year old. This history will bear some inspection because non-union at that age is very rare. At any rate, the disease was certainly not a fulminating one in the beginning.

His progress in the hospital is of little help, except that I judge he was not acutely ill. The laboratory data is all essentially negative. His only white blood count was elevated, but that could have been due to his throat infection.

We have two sets of X-rays, 23 days apart. The first ones, before admission, show a multilocular lesion involving the metaphysis and upper portion of the shaft, with symmetrical expansion of the cortex. There is an incomplete fracture, but no other break in the continuity of the cortex. This is important to remember, as well as the fact that there is no periosteal reaction.

The second set of films show several changes. I think there is further expansion of the cortex and the lesion has invaded upwards to include the last bit of metaphysis. There is also a change in the epiphysis. The X-ray Department reports involvement of the epiphysis. This is perhaps true, or the appearance may be due only to absorption of lime salts in that portion of the epiphysis. I am not sure of this point myself, and it is a pertinent factor. Certainly there is more distortion of the epiphyseal line itself. There is some increased density of some of the trabeculations crossing the lesion, which is consistent with the repair of the fracture. Also there is now a definite periosteal reaction on the same side as the fracture. I presume that this is reaction to the fracture. Here is another question which I cannot answer. If the periosteal reaction

is due only to the fracture, why do we not see it in the first films also? The fracture was then supposedly three months old. There is no reaction to be seen and yet there is a definite reaction only 23 days later.

In the differential diagnosis I rule out three common bone affections first:—tuberculosis, syphilis and osteomyelitis.

Now, what type of tumor best fits our picture? We have a central, expanding, destructive process in the metaphysis, associated with fracture, but without any other break in the cortex; without periosteal reaction of its own; and may be or may be not crossing the epiphyseal line; in a child of 5½ with symptoms for a year and a half. Is it a bone cyst or some other form of osteitis fibrosa cystica; giant-cell tumor; chondroma; chondroblastic sarcoma, or some form of osteolytic sarcoma?

Chondroma: This case has somewhat the X-ray appearance of a central chondroma, but that tumor is exceedingly rare in the long bones.

Chondroblastic Sarcoma: This is a possible diagnosis, though it is quite an unusual tumor. The child is a little young, (usual age incidence 10 to 20); the disease is more acute than in our case, and is seldom complicated by fracture. The location is ideal. This tumor is believed to start in the metaphysis and invade the epiphysis, which is, perhaps, exactly what ours has done. On the other hand, it always is accompanied by periosteal reaction, and I am going to assume that the reaction in our case is due to fracture.

Osteolytic Sarcoma: I mention this tumor because Geschicketer and Copeland say it is often confused with osteitis fibrosa cystica or giant-cell tumor. In 50% of the cases it is associated with fracture. It has the same location as our tumor, but it does not expand the bone much and there is early perforation of the bone shell. This does not fit into our picture.

Benign Giant-Cell Tumor: The age of our patient is against this diagnosis, as it is usually a disease of adults. It has a much shorter clinical course than our history would indicate. The tumor is asymmetrically placed and the bone-shell is usually perforated.

Bone Cyst: In most respects this best fits the picture. It is the most common of the lesions we have considered. The age is favorable, though our patient is a little young. The history of discovery because of fracture is typical. The average duration of symptoms is stated as 2½ years, and that is consistent with our case. The location of the tumor; the central destruction with symmetrical expansion; the intact bone shell and the lack of periosteal reaction, all fit our case. However, one glaring inconsistency which I cannot dismiss, makes it hard to accept this diagnosis. A bone cyst is presumably an "arrested lesion". Our X-rays showed progression in 23 days; there was more expansion of the cortex, a larger area of destruction, and there is again the question of whether or not there is invasion across the epiphyseal line.

Osteitis Fibrosa Cystica: Closely related to the above bone cyst is the acute bone cyst. This is sometimes called the giant-cell variant of the bone cyst. Both are forms of osteitis fibrosa cystica. It borders directly on the epiphyseal line and contains some giant-cell areas. Another related condition is known as polycystic osteitis fibrosa. These lesions are progressive by a sort of budding off of small cavities. This could explain the growth of our tumor in the time between X-rays. These latter variations of osteitis fibrosa cystica are not too clear in my mind, but as I understand them they could explain the discrepancies which exist between the typical bone cyst and the lesion in our case.

Therefore, this is my diagnosis: I believe this child's lesion is a form of osteitis fibrosa cystica, not the more common solitary bone cyst, but rather one of the more progressive forms, such as the so-called giant-cell variation of the bone cyst.

X-ray Discussion

Dr. Batchelder: There is a little break in the contour of the lateral portion of the upper end of the humerus, which may be a pathological fracture. There is an area of periosteal rarefaction at the same point. In the interval, there has been some change in the width of the cortex. Widening in the epiphyseal line is probably significant in that it means a further expansion of the process.

To come back to the original film and the evidence in which we thought there was probably a giant cell tumor with the obvious areas of fracture, was the expansion in the width of the bone, thinning of the cortex, and trabeculation running criss-cross across the lesion. The benign giant cell tumor does just that. There is no evidence of the peribenign malignant bone condition. Conclusion was finds and that would determine the probability of a osteal reaction of spicule formation that one usually that it probably was a benign condition near the end of bone up to the epiphyseal line, but not crossing it. In this one it is attempting to cross by pushing the epiphysis and diaphysis apart. That is evidence, at least, of a rapidly growing lesion which represents further evidence of some involvement of the epiphysis. No suggestion of atrophy, but rather disuse, with active involvement of a similar process. The areas of periosteal reaction is satisfactorily explained on the basis of repair and does not have the spicule formation which we usually associate with malignant bone tumor. Chest films negative.

Dr. Burton: Diagnosis lies in the x-ray findings. History is of no help and is at times contradictory. We assume the disease is not a primary one in any way, and is at least $1\frac{1}{2}$ years old. There was non-union of bone when the patient was at the Children's Hospital, and I think non-union in a child of that age is unusual.

Dr. Clarke: Any discussions of Dr. Burton's case?

Dr. Bowman: Do you expect more evidence of hyperparathyroid activity in this case?

Dr. Burton: There are several forms of osteogenic cystica in localized forms, and fall into three or four divisions, which are not too clear to me. This one might be in the subdivision which generally involves parathyroid hyperactivity with several locations in the skeleton. This one is apparently a little bit different in that it has one location.

Dr. Porter: Are there no other bone x-rays?

Dr. Burton: There was one of the shoulder.

Dr. B. Earl Clarke: Dr. Burton did not have the biopsy report. We received only three tiny bits of

tissue. The largest was 6 m.m. in its greatest diameter, so we did not have much to work with. At first glance at the histological preparations it appeared to be a giant cell tumor. However, we were disturbed by the spindle cell portion, between the giant cells. These varied in size and shape and there was a bit of osteoid tissue formation. I had seen two cases with similar histology that later proved to be malignant. The sections were submitted to several pathologists in Boston and it was the consensus of opinion that this was a malignant tumor. Radical surgery was advised. The patient was then discharged against advice.

Later he turned up at the Children's Hospital in Boston. On the basis of our material they advised operation and Dr. Ladd did a shoulder girdle resection. Dr. Farber sent me sections from the abundant material. There were areas typical of osteogenic sarcoma.

The postoperative course was uneventful. He was in good condition. The family was uncooperative and they lost sight of him in December, 1941. At that time he was apparently all right.

This then is a malignant tumor that pathologically resembled a benign giant cell tumor. The important question is, can a benign giant cell tumor change to become malignant? If so, then all giant cell tumors should be considered potentially malignant and radical treatment indicated. I do not know that we can be certain about this but I feel that when we have a biopsy with typical histology of a benign giant cell tumor conservative treatment is justified. On the other hand changes such as were found in this case probably were present from the beginning and signify malignancy.

Pathologic diagnosis: Osteogenic sarcoma.

Dr. Batchelder: This brings out that diagnosis cannot be made by x-ray conclusively. Very often it depends on biopsy, and certainly we can be a lot more certain with biopsy. X-rays are not proof, generally.

Incidentally, I saw the films at the Children's Hospital after the patient left. They showed a lesion about twice the size as shown here at that time and a definite break of the cortex.

BOOK REVIEWS

MANAGEMENT OF THE SICK INFANT AND CHILD by Langley Porter, M.D. and William E. Carter, M.D. C. V. Mosby Co., 1942.

This 6th edition of the well known text book on Pediatrics is even better than the previous editions. It brings the text up to date with the revision and additions.

The book is divided into twenty-seven chapters each taking up some special subject dealing with the sick child. Of course the regular subjects are well cared for but certain chapters are of especial interest. *General considerations*, a chapter for the general practitioner is most worth while. Besides chapters on the specific illnesses there are chapters on subjects of especial interest such as *pain, fever, cough, prematurity*, etc. A chapter on *behaviour* and one on *skin diseases* are of great usefulness because they are not always found in the general text book. *Allergy* and *infectious diseases* are also chapters of great interest to the average doctor.

The chapter on *methods* with its 95 pictures is extremely valuable to all who are not familiar with Pediatric procedures and the chapter on *drugs* and *poisoning* is most helpful.

I believe that this text is one of the best on Pediatrics and should be available to all who do not own a suitable text.

JOHN LANGDON, M.D.

CARCINOMA AND OTHER MALIGNANT LESIONS OF THE STOMACH by Waltman Walters, M.D., Howard K. Gray, M.D., James T. Priestley, M.D. and Associates in the Mayo Clinic and Mayo Foundation. 576 pages with 178 illustrations on 143 figures, 2 in colors. \$8.50. W. B. Saunders Company, 1942.

This book is a review of all cases, with a diagnosis of malignant disease of the stomach, seen at the Mayo Clinic from 1907 to 1938 inclusive. There were 11,000 patients. Of these cases 6,352 underwent operations in which there were 2,840 resections. 99% of these cases were carcinoma; 1% were lymphosarcoma, fibrosarcoma or Hodgkins disease.

There are twenty-three chapters, an appendix and index.

The short chapter on roentgenology by Kirklín is well worth reading and emphasizes the accuracy of X-ray diagnosis. By observance of technical details it is possible to make the diagnosis of gastric lesions in almost 100% of cases. It is not always possible to differentiate between cancer and ulcer. The examination by X-ray is also a great aid in determining the question of operability and resectability.

In the chapter on indications for treatment, the usual sites of metastasis are pointed out. The liver, umbilicus, and the left supraclavicular space are common sites. The sentinel node or Virchow's node is situated above the sternal end of the left clavicle. In case of doubt it can be removed for examination. Another frequent site is Blumer's rectal shelf. Digital examination of the rectum is advocated in every suspected case of carcinoma of the stomach.

The chapter on technic in the operating room describes the whole procedure from the preparation of the room, sterilization of instruments, up to the completion of the operation. The instruments and sutures used in various operations on the stomach are given in detail. The ordinary instruments used in a laparotomy are listed; for gastro-enterostomy and resection, the additional special instruments are listed. The method of closure with sizes of catgut is also described. One is impressed by the comparatively few and simple instruments used. These are to be found in every hospital.

There are fifty pages on anaesthesia. This chapter includes the estimation of the patient, preanaesthetic preparation and medication, and the agents and methods of anaesthesia. There are seven methods which may be used besides rectal or intravenous anaesthesia. The treatment of shock during the operation is well described.

In the avoidance of postoperative pulmonary complications, bronchoscopy is advised as inspiration of the throat and trachea to get rid of mucus is important. Oxygen therapy is mentioned.

The technic of the various resection operations is described in detail. The longitudinal muscle splitting incision is varied according to the location of the growth.

In gastric resection, the Polya operation either anterior or posterior is preferred—23.8% for the anterior and 45.6% for the posterior operation. More recently only 5% were performed by the anterior method. The posterior Polya modification of the Billroth II operation is particularly well described and well illustrated. Partial closure of the cut end of the stomach, Hofmeister method, is not recommended. In cases of very high resection or short mesocolons, the anterior Polya operation is performed.

The Billroth II operation is occasionally useful in debilitated patients in which case it is done in two stages.

The Billroth I operation and sleeve resection are seldom performed. Total gastrectomy is reserved for the exceptional case. Palliative gastro-enterostomy was performed in 951 cases.

Postoperative Care. Avoidance of exposure during the application of dressings, immediate application of heated blankets and use of Scultetus bandage are important. Oxygen and carbon dioxide mixture for ventilation of the lungs is valuable. Semi-sitting position in bed is the best. Sips of warm water are given after 48 hours, and, on the third day, weak tea, plain gelatin, milk and gruel. After this the diet is gradually increased.

In the administration of fluids, proctoclysis is recommended. In this way 2000 to 2500 cc. of fluid can be given daily with little discomfort. Hypodermoclysis of physiological saline solution is also of value. Intravenous fluids are not given without good cause. These statements, I believe, are sound. While it may be simpler to give all fluid by the vein, it is not necessarily the best way. Furthermore, the necessary personnel may not always be present. The routine use of the inlying Levin tube is not recommended. In some clinics this is routine.

Duodenal fistula occurs occasionally. The skin needs protection and aluminum paste or a paste of kaolin and olive oil are used. Suction is used. It can usually be avoided by meticulous closure of the duodenal stump.

Roentgenologic treatment of cancer of the stomach is used only in well selected cases. This is used only on inoperable cases or where operation has been refused, when the patient's general condition is good, he has not lost much weight and strength, cachexia is not pronounced and evidence of extensive metastasis is not obtained. In some of these cases substantial improvement was noted for several months and up to one or two years.

The chapter on prognosis and end results is very complete.

There were 10,890 cases in which the diagnosis of malignancy of the stomach was established during the period from 1907 to 1938 inclusive. In the preparation of this book, a painstaking examination of each case record was conducted. There was no operation in 4,648 cases, or 42.7%.

There were 6,242 operations or 57.3%. The operations were divided as follows: Exploration only, 2,431 or 22.3%; palliative procedure, 1,039 or 9.5%; resection, 2,772 or 25.5%.

In the cases of resection, of which there were 2,772, there were 450 hospital deaths. Autopsy was performed in 368 of these cases. The causes of death as found at autopsy are given in detail.

In the appendix there are very elaborate graphs and tables.

In conclusion, this book is a result of 32 years experience in 10,890 cases of malignancy of the stomach. It is a complete monograph and gives the whole procedure from diagnosis to end results. The book is extremely valuable and interesting reading. The simplicity of many of the procedures well allow the average surgeon to perform them.

CHARLES O. COOKE, M.D.

SYNOPSIS OF ANO-RECTAL DISEASES—Louis J. Hirschman, M.D., F.A.C.S. C. V. Mosby Company.

This is a compact book of 291 pages which reviews the ano-rectal diseases more or less from the clinicians standpoint. The phraseology is simple and direct and the subject matter is unusually well covered. The main emphasis is placed on the minor pathological conditions usually found in this region. The pathology and the operative procedures are well illustrated.

The chapters on Pruritus Ani, Constipation and Hemorrhoids stand out but most all of the chapters are good. The author's satire on the radio sales of constipation remedies and bile stimulants is amusing.

Dr. Hirschman offers many excellent suggestions which I believe worth mentioning. Among them are:—

"The tearing apart of sphincter fibers while a patient is helpless under anesthesia is brutal, unjustifiable, dangerous and unnecessary."

"The doctors as a whole do not give patients with ano-rectal diseases the thorough local and general examination necessary."

In doing a hemorrhoidectomy he condemns the use of sutures as "suturing closes a potentially infected wound." He also objects to cautery as it causes too much scarring.

About the injection treatment of hemorrhoids, on page 218 he states, "It seems more rational to remove the hemorrhoid by a cleancut surgical excision under local anesthesia and have the patient up and about on the second to fourth day, and the wound healed in from a week to ten days, than to use uncertain, palliative injection methods."

He repeatedly condemns the soap suds enema as being too irritating.

Dr. Hirschman, like most proctologists, resents having the general surgeon intrude on his territory and on many occasions he satisfies his whims by making remarks such as, "In doing hemorrhoidectomies some surgeons always use the lithotomy position; most proctologists do not." Such remarks are unnecessary. The Ultra specialists must realize that in small communities the general surgeon must do rectal surgery and also that there aren't enough proctologists to go around.

One statement made by Dr. Hirschman that an individual with megacolon had four or five bowel movements a year seems rather fantastic. If true I can't help but wonder at the weight lost on each occasion.

The book, however, is excellent and should be read by all physicians whether they are interested in proctology or not.

ANTHONY V. MIGLIACCIO, M.D.

NIGHT OF FLAME by Dyson Carter. Reynal & Hitchcock, New York.

"Night of Flame" is a novel which centers around a fracture ward in a large hospital. The story concerns the characterization of the patients, doctors and nurses—who are all a part of that ward. Some of the characters are—Gerard Stevens, a young doctor engaged to Joyce Rathwell, daughter of the hospital's wealthiest benefactor; Sonnie Draper,

the night charge nurse of East Five; Aileen Huntley, a student nurse, who imagines herself in love with the young, handsome Dr. Stevens; Dr. Rathwell, a remarkable surgeon, whose renown has been built mainly on his hands and his amazing will power, in a seeming battle against the slowness of his brain; Van Farman, a once famous flyer completely immobilized in a plaster cast as the result of an airplane crash; Larry Canfield, a young man brought to the hospital with a badly lacerated thigh, and who, upon learning that his leg is to be amputated, passes through a period when it is feared he may become mentally ill.

A fire breaks out in the X-ray storage vault, which is a fire-proof room on the roof. Doctors, nurses and patients show their courage and resourcefulness in their fight against this new danger of death. East Five is situated in the old section of the hospital and when it starts to burn there is no possible way of stopping it, although the fire's progress is checked somewhat by the excellent work of the fire department men.

After this large hospital fire each character's life is changed in some way. Dr. Stevens, instead of marrying a woman he does not love, eventually joins the army to be with the Medical Corps in England; Larry Canfield is offered a job in Chicago and he and Aileen Huntley decide to be married; Dr. Rathwell, whose hands are severely burned in the fire, loses his mind when he discovers that his skilful hands are no longer useful. Among the many who lose their lives is Sonnie Draper, who died while attempting to ease the last moments of Val Farman's life.

This book shows a complete understanding of human nature and a realization of the drama that goes on in the daily routine of a big hospital. It describes each individual's true character, deepest desires—every emotion—happiness and heart break.

It is very good "leisure time" reading matter.

HELEN F. ROSSI, R.N.

COMING MEETINGS

THE AMERICAN CONGRESS OF PHYSICAL THERAPY

Will hold its twenty-first annual scientific and clinical session September 9, 10, 11 and 12, 1942, inclusive, at the Hotel William Penn, Pittsburgh.

INTERNATIONAL COLLEGE OF SURGEONS NATIONAL ASSEMBLY

DENVER, COLORADO

July 15, 16, 17, and 18, 1942

The United States Assembly of the International College of Surgeons meets in a four-day session in Denver, Colorado, July 15-18. Headquarters and main assembly will be at the Shirley-Savoy Hotel.